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CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

HUMANA OF AURORA, INC. d/b/a AURORA COMMUNITY HOSPITAL

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

LAWRENCE G. WALLACE
Acting Solicitor General
Department of Justice
Washington, D.C. 20530
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BEST AVAILABLE COPY

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QUESTION PRESENTED

Whether the court of appeals erred in invalidating the regulation of the Secretary of Health and Human Services that established a formula for reimbursing hospitals for the portion of malpractice insurance costs attributable to Medicare patients.

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TABLE OF AUTHORITIES

Statutes:

Social Security Act, Tit. XVIII, 42 U.S.C. 1395 *et seq.*:

42 U.S.C. 1395f(b)(1)	2
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HUMANA OF AURORA, INC. d/b/a AURORA COMMUNITY HOSPITAL

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

The Acting Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Tenth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-9a) is reported at 753 F.2d 1579. The opinion of the district court (App., *infra*, 12a-18a) is unreported.

JURISDICTION

The judgment of the court of appeals (App., *infra*, 10a-11a) was entered on February 11, 1984. On May 5, 1985, Justice White extended the time for filing a petition for a writ of certiorari to June 14, 1985. On June 4, 1985, Justice White further extended the time for filing a petition for a writ of certiorari to July 11, 1985. The jurisdiction of this Court is invoked under 28 U.S.C. 1254 (1).

STATUTE INVOLVED

Title XVIII of the Social Security Act requires the Federal Hospital Insurance Trust Fund to reimburse hospitals for the "reasonable cost" of services provided to Medicare patients. 42 U.S.C. 1395f(b)(1); 42 U.S.C. 1395g(a). The Act defines "reasonable cost" as follows (42 U.S.C. 1395x(v)(1)(A)):

> The reasonable cost of any services shall be the cost actually incurred, * * * and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide

> for the use of estimates of costs of particular items or services * * *, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services * * * in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

STATEMENT

This case concerns the validity of a regulation (App., *infra*, 19a-27a), of the Secretary of Health and Human Services governing reimbursement of hospitals for the "reasonable cost" of treating Medicare patients. The specific issue is reimbursement of malpractice insurance premiums. The regulation and its statutory background are described in our petition for a writ of certiorari in *Heckler* v. *Abington Memorial Hospital*, which is being filed today.[1]

The present case involves the claim of a single hospital that sought reimbursement of its malpractice premium under the so-called "patient utilization" formula on the ground that the Secretary's ac-

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[1] A copy of the petition for a writ of certiorari in *Abington* is being served on counsel for respondent.

tion in replacing that formula with a "paid claims" formula was invalid. The district court upheld the validity of the rule and entered summary judgment in favor of the Secretary.

The court of appeals reversed. It held that the record failed to demonstrate that "the utilization method no longer worked," that any imbalance in malpractice reimbursement was not offset by countervailing imbalances in reimbursement of other overhead costs, or that there is any link between insurance premiums and paid claims (App., *infra*, 7a). In addition, the court held that there were fatal statistical flaws in the study on which the Secretary relied to show that the utilization formula resulted in reimbursement that was disproportionate to the actual claims that hospitals have paid to Medicare patients (*id.* at 6a, 8a-9a).

The court of appeals remanded the case to the district court "for further proceedings or for remand to the agency" (App., *infra*, 9a). Pursuant to the remand, the district court has entered a judgment against the Secretary in the amount of approximately $18,000.

REASONS FOR GRANTING THE PETITION

This case involves the same Medicare regulation that is involved in *Abington*, and that is the subject of the pending rulemaking proceeding described in our petition for a writ of certiorari in that case. As in *Abington*, the decision of the court of appeals in this case addresses several issues that may be resolved, or at least brought into sharper focus, by the pending rulemaking proceeding. Therefore, as in *Abington*, we believe that it would be appropriate for the judgment of the court of appeals to be vacated

and the case remanded for reconsideration in light of the current rulemaking proceeding.

CONCLUSION

The case should be disposed of in light of this Court's disposition in *Heckler* v. *Abington Memorial Hospital.*

Respectfully submitted.

LAWRENCE G. WALLACE
Acting Solicitor General *

JULY 1985

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* Acting Solicitor General Fried is disqualified in this case.

APPENDIX A

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

No. 83-2417

HUMANA OF AURORA, INC. d/b/a
AURORA COMMUNITY HOSPITAL,
PLAINTIFF-APPELLANT

v.

MARGARET M. HECKLER, Secretary of the
Department of Health and Human Services,
DEFENDANT-APPELLEE.

Appeal From The
United States District Court
For The District Of Colorado
(D.C. Civil No. 83-Z-70)

[Filed Feb. 11, 1985]

Before SEYMOUR, BREITENSTEIN and SETH, Circuit Judges.

SETH, Circuit Judge.

This appeal presents a challenge to the "Malpractice Rule," a regulation promulgated in 1979 by the Department of Health and Human Services. 42 C.F.R. § 405.452(b)(1)(ii). The rule is a substantial departure from the reimbursement methods previously used to compensate hospitals for care of Medicare patients. With the large increase in malpractice insurance costs, the Department had become convinced that hospitals were overpaid by Medicare for the costs of such insurance. *See* 44 Fed. Reg. 15,744, 15,745 (1979). Hospitals across the country unanimously opposed the change. This action and many others followed in the rule's wake.

Prior to the Malpractice Rule, a hospital's malpractice insurance costs were part of the "General and Administrative" cost center (G & A), a catchall category for many of the indirect costs of providing medical services. When it came time to apportion those G & A costs between Medicare and non-Medicare populations, the hospital's overall Medicare utilization ratio was applied to the G & A costs.

From the outset of the Medicare program, the Secretary realized certain G & A costs might be allocated disproportionately to Medicare or non-Medicare patients. It was concluded that any imprecision would be cured by the "averaging principle." Thus in an early policy statement the Department declared that "it is presumed that where a particular cost might be allocated disproportionately to or from the program, there will be other costs disproportionately allocated in the other direction which will compensate for the first cost." Intermediary Letter No. 234 (June 2, 1967). The averaging principle had been the guiding rationale. The new Malpractice Rule was a radical departure from the Department's his-

torical practice. *Cf.* Boswell Memorial Hospital v. Heckler, —— F.2d —— (D.C. Cir.), Nos. 83-2223, 83-2224, 83-2225.

In its Notice of Proposed Rulemaking (NPRM), the Department declared that the utilization method caused the Medicare program to pay an excessive portion of malpractice insurance costs. 44 Fed. Reg. 15,744, 15,745 (1979). To buttress this conclusion the Secretary referred to an unnamed "consultant's study" which supposedly established that malpractice damage awards were significantly lower for Medicare patients than for the general patient population. This difference stemmed from the shorter life expectancy of Medicare patients and their reduced earnings potential.

During the comment period public reaction was overwhelmingly negative. Hospitals attacked the statistical validity of the Department's study. Additionally, they elaborated upon the bizarre results that would follow from applications of the proposed rule. Nonetheless, the rule in its final form differed little from that proposed in the NPRM.

The rule excludes malpractice insurance costs from the G & A cost center and treats them as a separate item. Reimbursement is instead "based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current cost reporting period and the preceding 4-year period." 42 C.F.R. § 405.452(b)(1)(ii). This result obtains regardless of the extent of Medicare patient use of the hospital. The rule also makes provision for some compensation in the event a hospital has no paid claims during the five-year period. A "national ratio" of 5.1 per cent applies. This figure is a product of the same study that provided the impetus for the rule.

The appellant is a 200-bed acute care medical facility. In its 1980 cost report for Medicare the appellant made two claims for compensation which are now in dispute. Like many hospitals across the country, Humana did not apportion its malpractice insurance costs on the basis of the new Malpractice Rule. Instead, it presented a claim based on the old utilization method. Humana also presented a claim for other G & A costs it claimed were exclusively incurred on behalf of Medicare patients.

After following the administrative route the appellant filed suit in the United States District Court for the District of Colorado, seeking damages and declaratory and injunctive relief. Humana claimed the Malpractice Rule violated the substantive provisions of the Medicare Act because it failed to compensate the provider for its reasonable costs. 42 U.S.C. § 1395f(b). The appellant alleged the rule resulted in illegal "cross-subsidization," in contravention of section 1395x(v)(1)(A)(i) of the Act. Humana also claimed the rule was arbitrary and capricious and an abuse of the Secretary's discretion. 5 U.S.C. § 706(2)(a). Finally, Humana made a claim in the alternative for total reimbursement of other indirect G & A costs it viewed as exclusively attributable to the Medicare program. The crux of this claim is that if the Malpractice Rule is valid, then the averaging principle can no longer be a defense to attempts by providers at "discrete costing" other G & A items.

The parties filed cross-motions for summary judgment. The trial court ruled in favor of the Secretary. As to the substantive issues the court recognized that there might be "problems" with the Westat Report, the "consultant's study" used as a basis

for the new rule. Yet the court found that the Secretary had authority to employ different methods in calculating reimbursement. The rule, therefore, had "some basis" and was not arbitrary and capricious. The court found no fundamental discrepancy between using the averaging principle for all other G & A costs while parsing out malpractice insurance costs for separate treatment under the new rule. The court also rejected Humana's cross-subsidization argument. The court found nothing improper in the Department's refusal to provide complete reimbursement for the other G & A costs which Humana wished to treat as solely attributable to Medicare. The court held that the Secretary had a rational basis for altering the reimbursement formula.

Appellant asserts the contention that the new rule is an arbitrary and capricious exercise of the Secretary's informal rule-making authority under 5 U.S.C. § 760(2)(A). While the scope of review is narrow we must nevertheless act within the scope directed by the Supreme Court. Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402. The Supreme Court restated the standard of review in Motor Vehicle Manufacturers Association of the United States v. State Farm Mutual Automobile Insurance Co., —— U.S. ——, 103 S. Ct. 2856:

> "Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress had not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise."

A rational connection must be found between the facts before the agency and the rule-making choice made. *Id.* at 2866-67. *See also* Burlington Truck Lines v. United States, 371 U.S. 156, 168.

In the case before us we must conclude that the evidence that was before the agency is contrary to the administrative action ultimately taken. The fundamental nexus between evidence and agency action is absent. This is demonstrated by the deficiencies of the Westat Report, which the Report itself emphasizes. This is the unidentified "consultant's study" in the NPRM that purportedly justified the rule's promulgation.

This court must apply added requirements when there has been a significant departure from long-standing policy. Motor Vehicle Manufacturers Association of the United States v. State Farm Mutual Automobile Insurance Co., —— U.S. ——, 103 S. Ct. 2856, 2866. This court recently reiterated the requirements by the holding in Dimension Financial Corp. v. Board of Governors of the Federal Reserve System, —— F.2d —— (10th Cir.), No. 83-2696, that: "[T]he agency must clearly articulate the basis for the change. This is not only an aspect of any procedural notice requirement in rule-making but is a substantive need." *See also* Midwestern Transportation, Inc. v. I.C.C., 635 F.2d 771, 777 (10th Cir.).

Finally, the Secretary's discretion is limited also by the statutory scheme of the Medicare Act; some of the Act's directives are mandatory. *See, e.g.*, 42 U.S.C. § 1395x(v)(1)(A); St. John's Hickey Memorial Hospital v. Califano, 599 F.2d 803, 813 (7th Cir.).

We agree with the appellant that the rule-making record had to support two basic propositions. First,

the utilization apportionment approach had to overstate Medicare's share of malpractice insurance costs. Thus the record had to demonstrate that the utilization method no longer worked with regard to malpractice premium costs. Secondly, any imbalance in that expenditure had to evade the operation of the averaging principle. The rule-making record fails to establish these propositions.

One of the assumptions underlying the Malpractice Rule is that Medicare patients recover smaller malpractice awards than those persons in the general patient population. Thus the insurance costs for Medicare patients should be less. However, insurance premiums are derived from a variety of considerations. Risk cannot be calculated on the basis of one variable. Indeed, the Secretary acknowledged when issuing the rule in its final form that "insurance companies generally do not determine insurance rates for malpractice insurance based upon the financial status of the patients." 44 Fed. Reg. 31,642 (1979). Insurance rates depend on a broad pool of data, not on the isolated claims experience of a hospital during a defined time period. The Westat Report makes no pretense of linking insurance rates and paid claims. *See* Mt. Carmel Mercy Hospital v. Heckler, Medicare & Medicaid Guide (CCH) 33,529 at 9563 (E.D. Mich.).

It was also necessary for the rule-making record to show that Medicare patients filed few malpractice claims in relation to their use of hospital resources. The Secretary proffers the Westat Report in support of that proposition. The study itself acknowledges that it was based on a statistically insignificant sample with limits thereby placed on its application. We agree with the court in Abington

Memorial Hospital v. Heckler, 576 F. Supp. 1081, 1087, *aff'd*, 750 F.2d 242 (3d Cir.), that "an agency need not await perfect data before taking regulatory action. There are limits . . . to the degree of imperfection that is permissible . . . ." The Secretary exceeded those limits. When an agency adopts a regulation based on a study not designed for the purpose and which is limited and criticized by its authors on points essential to the use sought to be made of it, the administrative action is arbitrary and capricious and a clear error in judgment. Almay, Inc. v. Califano, 569 F.2d (D.C. Cir.). *Cf.* Camp v. Pitts, 411 U.S. 138, 143.

We base our conclusion not on our evaluation of the Report but on the limitations expressed in the Report itself. The Westat Report's authors warned that "[c]onclusions must be drawn very cautiously because of the possibility of biased data." Bias is apparent on several grounds. First, there is the problem of the size and limited time frame of the group studied. The Report examines the malpractice claims of nine insurance companies over a four-month period in 1976. Out of some 4,000 claims, only 166 are identified as originating with Medicare patients. Indeed, the Medicare status of a large portion of the same could not even be identified. Report at 5-9, 5-10. The authors again declared that the utility of the information is limited to the "time frame for which the data were collected and only to the universe of claims closed by the nine participating companies." Report at 2-9.

Additional sources of bias exist. The Report makes no attempt to distinguish between malpractice claims against hospitals and those against doctors, dentists, nursing homes, or other insureds. Report at 2-2. Sec-

ondly, the Report has no means of taking into account medical facilities that are self-insurers. *Id.* A sizable minority of hospitals self-insure, and their claims experience entirely evades the Report's scrutiny. Any one of these problems taken alone might be enough to invalidate the rule. However, these flaws taken as a whole render reliance by the agency on this "evidence" as irrational. The connection between the rulemaking record and the action ultimately taken is too attenuated to uphold the regulation.

Finally, we note that the Report in its most basic sense was never designed or intended by its makers to answer the questions or support the propositions the Secretary wished. *See* Report at 1-3. We hold, therefore, that the Malpractice Rule violates the provisions of the Administrative Procedure Act as an arbitrary and capricious exercise of the Secretary's informal rule-making powers.

Because of our disposition of the case under the Administrative Procedure Act we need not reach the appellant's argument that the Malpractice Rule results in cross-subsidization and thereby violates the substantive provisions of the Medicare Act.

In its alternative claim the appellant seeks compensation for what it views as Medicare's actual share of other G & A costs. In view of our disposition of the validity issue we do not reach this question nor the general adequacy of reimbursement.

The case is REVERSED and REMANDED to the District Court for further proceedings or for remand to the agency for resolution of appellant's claim for reimbursement. IT IS SO ORDERED.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

JANUARY TERM—February 11, 1985

No. 83-2417

(D.C. No. 83-Z-0070)

HUMANA OF AURORA, INC., d/b/a
AURORA COMMUNITY HOSPITAL,
PLAINTIFF-APPELLANT

v.

MARGARET M. HECKLER, Secretary of the
Department of Health and Human Services,
DEFENDANT-APPELLEE

JUDGMENT

Before Honorable Stephanie K. Seymour, Honorable Jean S. Breitenstein, and Honorable Oliver Seth, Circuit Judges

This cause came on to be heard on the record on appeal from the United States District Court for the District of Colorado, and was argued by counsel.

Upon consideration whereof, it is ordered that the judgment of that court is reversed. The cause is remanded to the United States District Court for the District of Colorado for further proceedings in accordance with the opinion of this Court.

/s/ Howard K. Phillips
HOWARD K. PHILLIPS
Clerk

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 83-Z-70

HUMANA OF AURORA, INC., d/b/a
AURORA COMMUNITY HOSPITAL, PLAINTIFF

v.

MARGARET M. HECKLER, Secretary of the
Department of Health and Human Services,
DEFENDANT

REPORTER'S TRANSCRIPT
(Hearing on Motions for Summary Judgment)

Proceedings before the HONORABLE ZITA L. WEINSHIENK, Judge, United States District Court for the District of Colorado, commencing at 8:20 a.m. on the 19th day of September, 1983, in Courtroom C-204, United States Courthouse, Denver, Colorado.

* * * * *

RULING

THE COURT: I appreciate the argument of both sides in this case, and I'm going to announce my decision on the record.

First of all, let me indicate that the Court does find the *Athens* opinion extremely persuasive. I think that the discussion on policy was thought out and was well considered in that opinion; and even though courts do not consider other District Court decisions as precedent, nevertheless the courts look to them for the reasoning of those decisions.

The standard for the Court in deciding this case is a question—and the court is not just substituting its judgment for that of the Secretary—which puts a great burden on the plaintiff. The standard, of course, is whether the decision of the Secretary may be set aside because it is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; so we're talking about violations of law, we're talking about arbitrary and capricious decisions in this case.

Basically, the plaintiff's claims break down into five counts that we're considering at this time: Whether under the APA, the decision is arbitrary and capricious; whether there as violation of tne Medicare act, and the issues contained in Count 6 concerning full reimbursement for actual costs.

After reading the briefs very carefully, after looking at the law available to the Court, and after listening to the argument this morning, the Court is convinced that the plaintiff's motion for summary judgment should be denied and the defendant's motion for summary judgment should be granted for the following reasons:

First of all, the procedures, as I have been able to ascertain, were valid under APA. There was no failure on procedure. The notice was adequate. The comments of the Secretary show that there were considered principles of other national organizations.

That is all that has to be shown—is that there was consideration of the principles. There doesn't have to be wholesale acceptance of the principles.

There is room, I would agree, for some innovative thinking and some methods to try to avoid the problems that had existed under the utilization method which resulted in the great overpayment by Medicare for malpractice insurance; and and I recognize the practical problems that come in here, where you do have elderly with lower life expectancy, with lower income, actually receiving a great deal less of the payments.

In any case, principles were considered by the Secretary, and there is not sufficient shown to indicate that the change or the decision was arbitrary and capricious on these grounds; and this was discussed in the *Athens* case, and I think well discussed.

Concerning the averaging principle argument, in this area also the Court cannot find that there was arbitrary and capricious methodology. The Westat Report did have problems, obviously. Nevertheless, even with problems, the study, along with the other information, could still be a sufficient basis for the Secretary's rule so that the decision made on that report, even though it had problems, along with the other information, would not be something which was arbitrary and capricious but rather had some basis.

The Government can use a number of different methods to determine reasonable costs to be reimbursed under the statute. I'm satisfied that this ability to use different methods is there—It is there by statutory permit—and certainly will give the Secretary some discretion to consider the factors that were considered in enacting the malpractice rule without having a District Court interfere and say-

ing, "Your decision—your discretion should be overruled and the Court's discretion or opinion substituted for that."

On the question of whether the—well, first of all, let me just cover the assumptions and the public policy argument about this rule is going to mean that malpractice cases will be settled, when the other cases are litigated. I have some real questions in my mind whether the underlying assumptions are correct in this argument; and I think the point made by Ms. Scott is that we have to assume good faith of the recipients. And time will tell whether there is problem in this regard; and if that problem does come to the fore, then the problem will have to be dealt with.

I just would point out again that the public policy of the State of Colorado is to settle cases, not to try them—settle cases if it can be done consistent with justice. So the public policy argument doesn't really grab me. It apparently didn't grab Judge Taylor in *Athens*, either.

The last point under Count 6 is a question of whether the plaintiff should be reimbursed on a hundred-percent basis. This is for the Secretary to decide in the first instance. This court is not in a position to adopt rules or procedures; and at this point, with the material before this court, I can see nothing arbitrary and capricious in the denial by the Secretary—the denial of this request. It appears to me that this may be an issue that may become the subject of rule-making in the future, where the Court can more specifically look to the rule and see what is happening; but at this point, there is nothing before this court to convince it that what the Secretary has done is arbitrary and capricious.

I see no—I see some problems, yes. I see some problems that have been very adequately pointed out by the plaintiff, with having the averaging method as far as a lot of administrative costs and so forth, and also having the malpractice rule. But I don't see that there is anything presented to this court which says that because these two considerations exist that the Court should interfere with the determination of the Secretary, with the discretion of the Secretary, and substitute its views for those of the Secretary.

I am absolutely not convinced that there is anything arbitrary and capricious with the method thus far worked out in having both methods.

Totally, the Court, in looking at this from the standard of review of whether there is a violation of law, No. 1, and whether there is a violation considering the facts and based on what the Secretary did, whether that action is arbitrary and capricious—the Court is not convinced that there is any violation of law, nor is the Court convinced that any action of the Secretary was arbitrary and capricious.

The Court recognizes that there is an obligation on the Secretary to look to the taxpayers' money that they spend for Medicare.

The Court certainly has had looked at the statute which indicates that the taxpayers are not supposed to be non-Medicare patients—are not supposed to bear the costs attributable to Medicare patients, and vice versa—the cross-subsidization rule; but I see no problem with a violation of that rule based on what was done in this case.

In other words, by ruling that the Medicare patients should not unduly and disproportionately pay for malpractice insurance, I don't think violates that statutory rule.

All in all, the Court is convinced at this time by a preponderance of the evidence that there is no violation of law, no arbitrary and capricious action; and therefore the Court does at this time grant the motion for summary judgment filed by the defendant, deny the motion for summary judgment filed by the plaintiff. And I leave it up to the Tenth Circuit, if the parties wish to bring this case up to the Circuit.

Let me just indicate to both parties that I do not intend to issue a written opinion. The opinion that I have given from the bench which is on the record will stand as the opinion of the Court. The Court will incorporate it by reference as if fully set forth; and if there is to be an appeal, the appeal will be taken from my remarks on the record.

Let me also indicate that I would suggest that there be no motion for reconsideration. I have thought about this long and hard before the argument. The argument has solidified some of the ideas that I had; and if the plaintiff intends to appeal, my suggestion is that they just file the appeal.

Unless there is anything further—is there anything further, Mr. Brock?

MR. BROCK: Yes, your Honor. I would like to make sure that I understand the Court's ruling as to Medicare participation costs. Is my understanding correct that the Court finds that the Secretary did not have the obligation to consider the claims for 100 per cent of reimbursement of the Medicare participation costs?

THE COURT. I don't understand your question.

MR. BROCK: I'm not sure if I understand whether you anticipate that Plaintiffs should return to the agency to present those claims to the admin-

istrator one more time, or if you are approving the —excuse me—the agency's decision not to adjudicate those claims.

THE COURT: Well, I take it there was a decision made by the agency, although no rule or regulation was adopted. Am I correct?

MR. BROCK: That's correct, your Honor.

THE COURT: All I'm saying is at this time I can find no action that was arbitrary and capricious concerning that action.

MR. BROCK: Thank you, your Honor.

THE COURT: Is there anything further from the defendant?

MR. GUTHRIE: No, your Honor.

THE COURT: All right. Thank you, and we will not recess court. We're going to go right on to the criminal matter, if we can just excuse the attorneys in this case.

The deputy clerk reminded me that I made no ruling on costs; and my intention is that each side should pay its own costs in this matter. That will also be part of the order.

APPENDIX D

44 Fed. Reg. 31641 (1979)

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

Health Care Financing Administration

42 CFR Part 405

Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Direct Apportionment of Malpractice Costs to Medicare

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Final rule.

SUMMARY: This amendment requires malpractice costs incurred by a provider to be directly apportioned to Medicare based on Medicare malpractice loss experience, instead of the current apportionment basis of Medicare's overall utilization of provider services. It requires a separate accumulation and direct apportionment of malpractice insurance premiums and self-insurance fund contributions. In addition, when a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, as a result of the application of deductible or coinsurance provisions of a purchased insurance policy, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, Medicare will reimburse the costs of these losses and any related direct costs. The purpose is to reimburse Medicare providers on a basis more closely related to actual malpractice experience.

DATE: Effective July 1, 1979.

FOR FURTHER INFORMATION CONTACT: Mr. Hugh McConville, (301) 594-9682.

SUPPLEMENTARY INFORMATION:

Background

Under sections 1814(b) and 1833(a)(2)(A) of the Social Security Act, providers of services are to be paid the lesser of reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. Section 1861(v)(1)(A) of the Act defines reasonable cost and authorizes the Secretary to issue regulations establishing the methods to be used and items to be included in determining reasonable costs. These regulations are set forth in 42 CFR Part 405, Subpart D.

Under current regulations and other instructions issued by Medicare, malpractice costs are accumulated in the administrative and general cost center and allocated to the revenue-producing and other cost centers on the statistical basis of accumulated costs. The costs in the revenue-producing cost centers, including appropriate allocated overhead costs, are then apportioned to Medicare using the ratio of Medicare charges to total charges, or another appropriate statistical basis for ancillary and outpatient services, and the average cost per diem for Medicare beneficiaries for general routine and special care unit services.

This method results in Medicare paying a disproportionate amount of malpractice costs. A national study conducted by a DHEW consultant indicates that malpractice awards for Medicare patients are

significantly lower in amount than losses for other patient population. The lower awards for Medicare patients result because the income potential and life expectancy of these patients are less than the non-Medicare population. Thus, the use of overall Medicare utilization to allocate malpractice costs results in Medicare's paying a disproportionate amount of malpractice costs.

This amendment avoids these disproportionate payments by restructuring the cost finding and cost apportionment procedure. Costs of malpractice insurance premiums and self-insurance fund contributions will be accumulated in a specific malpractice cost center and directly apportioned to Medicare based on the provider's Medicare malpractice loss experience. The dollar ratio of malpractice losses paid for Medicare beneficiaries to total malpractice losses paid for all patients for the current cost reporting period and the preceding 4-year period will provide the basis for apportioning these malpractice costs to Medicare.

The use of an actuarial estimate when a provider has minimal malpractice losses during the 5-year period, as proposed in the Notice of Proposed Rulemaking, could also have resulted in Medicare sharing disproportionately in malpractice costs. Therefore, the final regulation has been revised to require a provider to use the national ratio of the dollar value of Medicare malpractice awards to total malpractice awards as determined by the 1976 Departmental closed claim study performed by Westat, Inc. This national ratio, as determined by the latest study, is 5.1 to 100 or 5.1 percent and is to be used instead of an actuarial estimate for apportioning malpractice insurance premiums or self-insurance fund contributions. When a provider has no malpractice loss ex-

perience for the 5-year period specified in the final regulation, Medicaid reimbursement of malpractice insurance premiums or self-insurance fund contributions would be determined by applying the national ratio of 7.5 to 100 (or 7.5 percent). This ratio was also determined by the most recent Departmental study of closed claims.

If a provider pays allowable uninsured malpractice losses for Medicare beneficiaries, as a result of the application of deductible or coinsurance provisions of a purchased insurance policy or a funded self-insurance program, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, those losses and related direct costs will be directly assigned to Medicare for reimbursement.

This regulation impacts Medicaid reimbursement because under 42 CFR 447.261(b)(2), for payment of inpatient hospital services, States participating in Medicaid must either adopt Medicare standards and principles for determining reasonable cost reimbursement as set forth in 42 CFR 405.402 through 405.455 or must meet the criteria in 42 CFR 447.261(d).

Discussion of Major Comments

A Notice of Proposed Rulemaking for this regulation was published on March 15, 1979, in the Federal Register (44 FR 15641). Comments were received from many members of the health care industry. Responses to the most significant comments are described below.

1. *Opposition to the Direct Apportionment of Malpractice Costs.* All comments received were against the proposal and recommended that we withdraw it entirely. The main argument against the proposal

was that the incurrence of malpractice costs bears no relationship to the financial class of the patient. Therefore, all patients should share equally in malpractice insurance costs or losses because these costs are incurred primarily for the benefit of the total overall patient population and for the protection of facility assets. Other arguments stressed that charges to private patients and third-party payors would necessarily increase in order to recover costs normally reimbursed by Medicare, and that additional costs for recordkeeping would be incurred.

We are aware that insurance companies generally do not determine insurance rates for malpractice insurance based upon the financial status of the patients. However, information about malpractice loss experience by type of patient (i.e., Medicare) is readily available. Moreover, this regulation is not based on a relationship between malpractice losses and the financial status of patients. As explained above, it is grounded on a direct calculation of the costs incurred in furnishing health care to Medicare beneficiaries.

We are also aware that charges to private patients and third-party payors may increase and that additional costs for recordkeeping may be incurred; we believe that this amendment is necessary in order to prevent the program from paying a disproportionate amount of substantial malpractice costs.

2. *Direct Assignment of Overhead Costs.* We received comments urging that overhead costs other than malpractice costs also be directly apportioned. We believe that the current cost finding and apportionment procedure is generally an equitable method of allocating other overhead costs. However, because malpractice costs are so significant and the dispro-

portionate allocation of malpractice costs to Medicare is so great, we believe a unique exception is warranted to deal with these costs.

3. *Cash Flow.* We received comments concerning the possibility of the apportionment ratio adversely affecting provider cash flow. If a provider pays a large dollar amount of Medicare malpractice claims in the current year and has little or no prior Medicare malpractice claim experience for the preceding 4-year period, the apportionment ratio of Medicare malpractice claim loss experience to total malpractice claim loss experience for the current period necessarily becomes smaller due to the averaging of the malpractice loss experience ratios for the entire 5-year period. Over the succeeding 5-year period, reimbursement would eventually reflect Medicare's malpractice claim experience. However, for the current year, the apportionment ratio (5-year average) would apportion to Medicare an amount less than what would have been apportioned had the current year's ratio for malpractice claim loss experience been used, thereby lowering Medicare reimbursement. Providers, therefore, would have to use their own funds until such time as Medicare reimbursement "catches up."

We wish to study this issue further, especially when circumstances are reversed and Medicare payment is greater than it might otherwise be, due to a particularly large malpractice claim in a given year. One possible solution could be a modification to 42 CFR section 405.454(h), Accelerated payments to providers, to provide relief to providers whose cash flow is adversely affected by the apportionment ratio. If so, a proposed change to this regulation section would be published in the Federal Register for comment.

4. *Claims Management.* We also received comments stating that this regulation would provide an incentive for providers to settle Medicare malpractice claims without providing the same degree of claims management as for non-Medicare malpractice claims of similar nature. We do not believe that providers would actually settle Medicare malpractice claims in such a manner. Furthermore, we do not believe that others involved in such matters, such as legal firms, insurance companies, and insurers would allow these practices. However, we will watch this carefully and take action if necessary.

EFFECTIVE DATE: This amendment to the Medicare reimbursement regulations is effective for cost reporting periods beginning on or after July 1, 1979. Instructions will be provided through fiscal intermediaries for the treatment of malpractice costs for these periods and cost reporting forms will be supplied before filing.

42 CFR Part 405 is amended as follows:

1. Section 405.452 is amended by revising paragraph (b) (1) to read as follows:

§ 405.452 Determination of cost of services to beneficiaries.

* * * * *

(b) *Principle for cost reporting periods starting after December 31, 1971.* Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. For cost reporting periods starting after December 31, 1971, the methods of apportionment are defined as follows:

(1) *Departmental Method.* (i) Except as provided in paragraph (b)(1)(ii) of this section with respect to the direct apportionment of malpractice costs, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program, beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas, taking into account, to the extent pertinent, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential), and in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other special care inpatient hospital units.

(ii) *Exception:* For cost reporting periods beginning on or after July 1, 1979, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned to Medicare. The apportionment must be based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current cost reporting period and the preceding 4-year period. If a provider has no malpractice loss experience for the 5-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned to Medicare based on the national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients. The Health Care Financing Administration will calculate this ratio periodically based on the most recent departmental closed claim study.

If a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, either

through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to Medicare for reimbursement.

(Sections 1102, 1814(b), 1881(v)(1) of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395x(v), 1395hh).)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance; No. 13,774. Medicare—Supplementary Medical Insurance.)

Dated: May 23, 1979.

Leonard D. Shaeffer,
Administrator, Health Care Financing Administration.

Approved: May 24, 1979

Joseph A. Califano, Jr.
Secretary.

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